Second Victims

Perioperative Pressure Ulcers

The Strength of Action Items

SECOND VICTIMS

In April 2011, a nurse committed suicide just 7 months after making a mathematical error that led to an overdose and subsequent death of a critically ill infant. The nurse’s employment was terminated for undisclosed reasons after 27 years of service. She paid a fine and accepted a 4-year probation that included oversight of her medication administration at any future nursing job. At the time of her death, she had been unable to find another position. (Too Many Abandon the “Second Victims” of Medical Errors’, Institute for Safe Medication Practices, July 14, 2011 issue)

Healthcare workers who are involved in a medical error or adverse event that harms or causes a patient’s death experience intense emotional turmoil equivalent to post-traumatic-stress disorder (PTSD) (Rassin and Silner, “Chronology of medication errors by nurses: accumulation of stresses and PTSD symptoms”, Issues Ment. Health Nurs., 2005) In these situations, the healthcare provider becomes the ‘second victim’ of the medical error/adverse event.

The second victim phenomenon can occur to any healthcare provider, and as many as half of all providers will experience the repercussions at least once in their career (Seys, Wu, et al, “Health Care Professionals as Second Victims after Adverse Events: A Systematic Review”, Eval. Health Prof., 2013). There are numerous ways the distress may manifest itself and it will vary depending on the individual.

### Second Victim Symptoms (University of Missouri)

<table>
<thead>
<tr>
<th>Physical Symptoms</th>
<th>Psychological Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleep disturbances</td>
<td>Isolation</td>
</tr>
<tr>
<td>Difficulty concentrating</td>
<td>Frustration</td>
</tr>
<tr>
<td>Eating disturbances</td>
<td>Fear</td>
</tr>
<tr>
<td>Headache</td>
<td>Uncomfortable returning to work</td>
</tr>
<tr>
<td>Fatigue</td>
<td>Anger and irritability</td>
</tr>
<tr>
<td>Nausea or vomiting</td>
<td>Depression</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>Extreme sadness</td>
</tr>
<tr>
<td>Rapid heart rate</td>
<td>Self-doubt</td>
</tr>
<tr>
<td>Rapid breathing</td>
<td>Flashbacks</td>
</tr>
<tr>
<td>Muscle tension</td>
<td>Feeling numb</td>
</tr>
</tbody>
</table>
SECOND VICTIMS, CONTINUED

- Tier 3 - this is a referral process and ensures availability and prompt access to professional counseling and guidance services for clinicians requiring support beyond the capabilities of the trained team members.

MUHC identified six stages of the Second Victim Trajectory:
1) Chaos & Accident Response (How/why did that happen?);
2) Intrusive Reflections (What did I miss? Could this have been prevented?);
3) Restoring Personal Integrity (What will others think? How much trouble am I in? Will I ever be trusted again?);
4) Enduring the Investigation (What happens next? Who can I talk to? Will I lose my job/license?);
5) Obtaining Emotional First Aid (What is wrong with me? Do I need help? Where can I turn for help?); and
6) Moving On (three trajectory options):
   a. Dropping out (Is this the profession I should be in? Can I handle the work?)
   b. Surviving (Why do I still feel so badly/guilty?)
   c. Thriving (What can I do to improve patient safety? What can I learn from this?).

Various resources are available from the MUHC forYou Program at:

A five year study of the MUHC forYOU program revealed the following conclusions:
- An organization’s awareness of the second victim phenomenon and a facility response plan are crucial steps in minimizing the suffering of the facility’s healthcare staff.
- It is strongly suggested for healthcare facilities to develop a complete response plan and provide accessible and effective support for all clinicians who experience the second victim phenomenon.
- This support should begin the moment the unanticipated/adverse event is recognized.
- Peer and social support initiatives should be established with information about them widely distributed so staff know what support is available, what can be expected, and how to access help when they experience such an event.
- Staff support must be a predictable, required part of the healthcare operational response to stressful clinical events.

The link to the article is below:
http://www.psqh.com/analysis/clinician-support-five-years-of-lessons-learned/

PERIOPERATIVE PRESSURE ULCERS

Pressure Ulcers (PUs) are the second most reported sentinel event for Maine in 2016. Providers’ attitudes toward the prevention of PUs may be ambivalent when the PU occurs in a critically ill patient, as they may view the PU as a relatively minor issue given the overall complexity of the patient’s condition. While it is acknowledged that high risk clinical situations can lead to unavoidable PUs, the 2010 Consensus Conference held by the National Pressure Ulcer Advisory Panel (NPUAP) stated that PU prevention should be provided and no predetermination of PU development should be made, regardless of setting (Black, et al, Ostomy Wound Management, 2011).

One setting that may not be considered in PU prevention programs is the operating room (OR). However, in a 2016 article in Patient Safety and Quality Healthcare, “Perioperative Pressure Injuries: Protocols and Evidence-Based Programs for Reducing Risk” Scott, et al write that pressure injuries may develop when a patient undergoes surgery due to the body’s response to immobility. Even a relatively short, two-hour surgical procedure can result in six hours of immobility for the patient. Because PUs often do not present until hours or days after a surgery is completed, OR staff and surgeons may not even think about PU prevention. This perception is born out in PU cases reviewed by the SET. We have not yet received a case where the OR was identified as the setting where the PU may have started, and OR staff were included in the RCA.

There are numerous factors that increase risk for developing a PU with a surgical patient, including: age over than 60; BMI over 40 or less than 19; diabetes; renal insufficiency; pulmonary disease; duration of immobilization prior to surgery; operation of 3 hours or longer; trauma; use of vasopressors and reduced mobility on first post-operative day. Trigger tools may be useful to identify surgical patients at high risk of developing PUs. Two tools specific to surgical patients are the Scott Triggers Tool and the Munro Pressure Ulcer Risk Assessment Scale for Perioperative Patients. Both toolkits, and many additional resources, can be found at the Association of Perioperative Registered Nurses website:
https://www.aorn.org/guidelines/clinical-resources/toolkits/prevention-of-perioperative-pressure-ulcers-tool-kit

If a patient is identified as high risk for developing a PU, an OR skin bundle protocol may be used to decrease the risk of harm. A skin bundle should include evidence-based practice interventions such as: skin assessments pre-operatively and immediately post-operatively; standardization of high-specification OR table pads; use of protective dressings and approved positioning devices; and handoff communication. Another intervention that can help reduce Perioperative PUs is implementation of a Perioperative Pressure Injury Prevention Program (PPIPP).
### The Strength of Action Items, Continued

Corrective action plans are historically the weakest portion in the RCA process for various reasons. The SET reviews many RCAs and has identified an opportunity to improve, for a number of facilities, in the development of effective action items. Many action items received by the SET revolve around staff education. While this is a relatively easy action item to implement, it is less effective in evincing strong, sustainable process improvement.

The Veterans Administration (VA) Center for Patient Safety has developed a comprehensive set of Root Cause Analysis Tools which is available at: [http://www.patientsafety.va.gov/docs/joe/rca_tools_2_15.pdf](http://www.patientsafety.va.gov/docs/joe/rca_tools_2_15.pdf)

The VA Root Cause Analysis Tool describes action strength as being based on the principles of human factors where the most effective actions accommodate or control for the limitations of human behavior and how people interact with systems, tools, tasks and the environment through the use of design and standardizations.

**Stronger Actions** – these actions are the best at removing the dependence on humans to ‘get it right’ (the changes are physical and permanent, rather than procedural and temporary). Questions to ask in evaluating if the action is stronger in preventing the event/cause include:

- Does the action force the person to get it right?
- Does it eliminate the chance to choose the wrong option?
- Is it designed for the environment or system to operate without additional issues/concerns for the person taking the action?
- Can it be replicated successfully?
- Does it require minimal supervision or measurement of compliance?
- Does it involve standardized forcing functions to remove human error and variation through technology or design?

Example: Developing a computer login system that will not accept passwords that don’t contain defined features (e.g. at least 8 characters and contains a combination of upper & lower case letters, numbers or symbols)

**Intermediate Actions** – these actions reduce reliance on humans to get it right, but do not fully control human error. Questions to ask in evaluating if the action is of intermediate strength include:

- Does the action help the person remember the process?
- Does it improve upon the information needed to do the process?
- Does it serve as a guide tool during the process?
- Does it reduce variation of the outcome (most people can do it successfully)?
- Does it account for human limitations: time, workload, task?

Example: Use of a checklist that outlines the steps necessary to login to the computer system.

**Weaker Actions** – these support/clarify the process but rely solely on the human. Questions to ask for weaker actions:

- Is the action focused on informing the person?
- Does it establish rules that do not already exist?
- Does it prompt, warn or alert the person (capture their attention)?
- Does it examine if a process could be improved/made better?
- Is the outcome of the action left up to personal interpretation?

Example: Computer users are directed to choose unique passwords for system accounts.
UPDATES FROM THE SENTINEL EVENT TEAM

Best Practice: The SET on-site review at C. A. Dean Hospital identified a “best practice” for sentinel event education. This hospital’s education was thorough, detailed and specific to the State of Maine SE program. Of particular note was inclusion of examples of SEs and mini case studies to help staff members gain a practical understanding of SEs and the organization’s process for reporting and investigating these events. Also impressive was the competency exam that demonstrates learning comprehension. Great work, C.A. Dean!

Timeliness of Reporting: According to SE Rules Sections 3.1 and 3.2, “the healthcare facility must notify the SET of a SE by the next business day after the event occurred or the next business day after the facility discovers that the event occurred...Notification must not be delayed secondary to internal deliberations...” The SET would like to clarify that “discovery” of a SE occurs when the event is identified by staff or medical staff members, not when it comes to the attention of the risk/quality department (sometimes weeks or months after the actual event occurred). The requirement for training of all staff and medical staff members regarding SEs is to ensure that there will be timely reporting of SEs to the SET and initiation of the RCA process as soon as possible after the event. While the SET is aware that facilities may have an internal review team for assessing and analyzing SEs, we encourage facilities to report any event that may meet SE criteria. The SET will help facilities determine if the event meets SE criteria.